		FOR OHF USE					

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033340

Facility Name: AVENUE CARE CENTER

Address: 4505 S. DREXEL (Number) CHICAGO (City) 60603 (Zip Code)

County: COOK

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-3558590

Date of Initial License for Current Owners: 02/01/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) SHERWIN I. RAY

(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA/PARTNER

(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD
3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	155	Skilled (SNF)	155	56,730	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,730	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,853	1,853	8
9	SNF/PED					9
10	ICF	42,908	715	107	43,730	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	42,908	715	1,960	45,583	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.35%

D. How many bed-hold days during this year were paid by Public Aid?
196 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 21 and days of care provided 1853

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	121,870	19,830	5,260	146,960		146,960	3,008	149,968			1
2	Food Purchase		186,151		186,151	(20,093)	166,058	(606)	165,452			2
3	Housekeeping	110,416	24,339	0	134,755		134,755	0	134,755			3
4	Laundry	44,016	19,491	0	63,507		63,507	0	63,507			4
5	Heat and Other Utilities			114,950	114,950		114,950	378	115,328			5
6	Maintenance	33,813	28,316	47,876	110,005		110,005	13,332	123,337			6
7	Other (specify):*			12,022	12,022		12,022	0	12,022			7
8	TOTAL General Services	310,115	278,127	180,108	768,350	(20,093)	748,257	16,112	764,369			8
	B. Health Care and Programs											
9	Medical Director			0				0				9
10	Nursing and Medical Records	1,116,468	36,527	1,814	1,154,809		1,154,809	21,837	1,176,646			10
10a	Therapy	49,522	3,056	26,438	79,016		79,016	(1,892)	77,124			10a
11	Activities	66,078	5,113	3,429	74,620		74,620	0	74,620			11
12	Social Services	25,922		4,861	30,783		30,783	0	30,783			12
13	Nurse Aide Training			0				0				13
14	Program Transportation			958	958		958	0	958			14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	1,257,990	44,696	37,500	1,340,186		1,340,186	19,945	1,360,131			16
	C. General Administration											
17	Administrative	65,974		286,000	351,974		351,974	(240,350)	111,624			17
18	Directors Fees			0				0				18
19	Professional Services			186,589	186,589		186,589	(143,283)	43,306			19
20	Dues, Fees, Subscriptions & Promotions			23,791	23,791		23,791	(1,729)	22,062			20
21	Clerical & General Office Expenses	76,628	11,540	107,804	195,972		195,972	(21,436)	174,536			21
22	Employee Benefits & Payroll Taxes			263,608	263,608	20,093	283,701	0	283,701			22
23	Inservice Training & Education			1,590	1,590		1,590	886	2,476			23
24	Travel and Seminar			0				98	98			24
25	Other Admin. Staff Transportation			648	648		648	1,118	1,766			25
26	Insurance-Prop.Liab.Malpractice			74,080	74,080		74,080	3,326	77,406			26
27	Other (specify):*			0				23,153	23,153			27
28	TOTAL General Administration	142,602	11,540	944,110	1,098,252	20,093	1,118,345	(378,217)	740,128			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,710,707	334,363	1,161,718	3,206,788		3,206,788	(342,160)	2,864,628			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			33,882	33,882		33,882	124,038	157,920			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			3,042	3,042		3,042	399,585	402,627			32
33	Real Estate Taxes			156,454	156,454		156,454	0	156,454			33
34	Rent-Facility & Grounds			464,438	464,438		464,438	(459,408)	5,030			34
35	Rent-Equipment & Vehicles			26,216	26,216		26,216	(8,505)	17,711			35
36	Other (specify):*							0				36
37	TOTAL Ownership			684,032	684,032		684,032	55,710	739,742			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		32,472	94,137	126,609		126,609	(26,515)	100,094			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			85,096	85,096		85,096	0	85,096			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		32,472	179,233	211,705		211,705	(26,515)	185,190			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,710,707	366,835	2,024,983	4,102,525	0	4,102,525	(312,965)	3,789,560			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(3,447)	30		9
10	Interest and Other Investment Income	(46)	32		10
11	Discounts, Allowances, Rebates & Refunds		2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(606)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(54)	20		17
18	Fines and Penalties	(5,902)	21		18
19	Entertainment	0	20		19
20	Contributions	(121)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(1,979)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(649)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	2,481	6		29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (10,323)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(302,642)	SCHED	34
35	Other- Attach Schedule	0	ITACHED	35
36	SUBTOTAL (B): (sum of lines 31-35)	$ (302,642)		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (312,965)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

Print Preview

Detail lines 29 and 29 of Page 9 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 9A**

Facility Name AVENUE CARE CENTER

IDH 0032049

Report Period Beginning: 7/1/2008

Ending: 12/31/2008

NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference
The information listed in B13 thru G65 is from Page 5.		
1 **Day Care**	0	0
2 **Other Care for Outpatients**	0	0
3 **Governmental Sponsored Special Programs**	0	0
4 **Non-Patient Meals**	0	2
5 **Telephone, TV & Radio in Resident Rooms**	0	0
6 **Rented Facility Space**	0	34
7 **Sale of Supplies to Non-Patients**	0	10
8 **Laundry for Non-Patients**	0	4
9 **Non-Straight-line Depreciation**	(3,447)	30
10 **Interest and Other Investment Income**	(86)	32
11 **Discounts, Allowances, Rebates & Refunds**	0	2
12 **Non-Working Officer's or Owner's Salary**	0	0
13 **Sales Tax**	(606)	2
14 **Non-Care Related Interest**	0	32
15 **Non-Care Related Owner's Transactions**	0	0
16 **Personal Expenses (Including Transportation)**	0	25
17 **Non-Care Related Fees**	(16)	20
18 **Fines and Penalties**	(5,902)	21
19 **Entertainment**	0	20
20 **Contributions**	(123)	20
21 **Owner or Key Man Insurance**	0	22
22 **Special Legal Fees & Legal Retainers**	0	19
23 **Malpractice Insurance for Individuals**	0	26
24 **Bad Debt**	0	27
25 **Fund Raising, Advertising and Promotional**	(1,979)	20
26 **Income & Ill. Personal Property Replacement Taxes**	0	0
27 **Nurse Aide Training for Non-Employees**	0	13
28 **Yellow Page Advertising**	(648)	20
29 **Non-Paid Workers**	0	0
30 **Donated Goods**	0	0
31 **Amortization Expense**	0	0
32 Deferred Maintenance SFS 01	2,481	6

	Sch V Line	Adj. Summary
Line 1	0	0
Line 2	(606)	(606)
Line 3	0	0
Line 4	2	2
Line 5	0	0
Line 6	34	34
Line 7	10	10
Line 8	4	4
Line 9	30	30
Line 10	32	32
Line 10a	2	2
Line 11	0	0
Line 12	0	0
Line 13	0	0
Line 14	0	0
Line 15	0	0
Line 16	25	25
Line 17	20	20
Line 18	21	21
Line 19	20	20
Line 20	22	22
Line 21	(5,902)	(5,902)
Line 22	19	19
Line 23	26	26
Line 24	27	27
Line 25	(1,979)	(1,979)
Line 26	0	0
Line 27	13	13
Line 28	(648)	(648)
Line 29	0	0
Line 30	(4,331)	(4,331)
Line 31	0	0
Line 32	6	6
Line 33	0	0
Line 34	0	0
Line 35	0	0
Line 36	0	0
Line 37	(1,441)	(1,441)
Line 38	0	0
Line 39	0	0
Line 40	0	0
Line 41	0	0
Line 42	0	0
Line 43	0	0
Line 44	0	0
Line 45	(10,313)	(10,313)

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

Print Other Adjustments

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	3,008	0	0	0	0	0	0	0	0	0	3,008	1
2	Food Purchase	(606)	0	0	0	0	0	0	0	0	0	0	(606)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	378	0	0	0	0	0	0	0	0	0	378	5
6	Maintenance	2,481	10,851	0	0	0	0	0	0	0	0	0	13,332	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	1,875	14,237	0	0	0	0	0	0	0	0	0	16,112	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	21,837	0	0	0	0	0	0	0	0	0	21,837	10
10a	Therapy	0	5,838	0	(7,730)	0	0	0	0	0	0	0	(1,892)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	27,675	0	(7,730)	0	0	0	0	0	0	0	19,945	16
	C. General Administration													
17	Administrative	0	(240,350)	0	0	0	0	0	0	0	0	0	(240,350)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(143,283)	0	0	0	0	0	0	0	0	0	(143,283)	19
20	Fees, Subscriptions & Promotions	(2,803)	0	1,074	0	0	0	0	0	0	0	0	(1,729)	20
21	Clerical & General Office Expenses	(5,902)	(68,200)	52,666	0	0	0	0	0	0	0	0	(21,436)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	886	0	0	0	0	0	0	0	0	886	23
24	Travel and Seminar	0	0	98	0	0	0	0	0	0	0	0	98	24
25	Other Admin. Staff Transportation	0	0	1,118	0	0	0	0	0	0	0	0	1,118	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,326	0	0	0	0	0	0	0	0	3,326	26
27	Other (specify):*	0	0	23,153	0	0	0	0	0	0	0	0	23,153	27
28	**TOTAL General Administration**	(8,705)	(451,833)	82,321	0	0	0	0	0	0	0	0	(378,217)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(6,830)	(409,921)	82,321	(7,730)	0	0	0	0	0	0	0	(342,160)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(3,447)	0	127,485	0	0	0	0	0	0	0	0	124,038	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(46)	0	399,631	0	0	0	0	0	0	0	0	399,585	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(459,408)	0	0	0	0	0	0	0	0	(459,408)	34
35	Rent-Equipment & Vehicles	0	0	(8,505)	0	0	0	0	0	0	0	0	(8,505)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,493)	0	59,203	0	0	0	0	0	0	0	0	55,710	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(26,515)	0	0	0	0	0	0	0	(26,515)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	(26,515)	0	0	0	0	0	0	0	(26,515)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(10,323)	(409,921)	141,524	(34,245)	0	0	0	0	0	0	0	(312,965)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Page 6

Facility Name & ID Number: AVENUE CARE CENTEI — # 093340 — Report Period Beginning: 01/01/2000 — Ending: 12/31/2000

VII. RELATED PARTIES

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE				CAREPLUS MGMT	NILES	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
				AVENUE ASSOC	NILES	THERAPY
				LLC		REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization — Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference; Adjustments for Related Organization Costs (7 minus 6)		Sum. 6
V	17	MANAGEMENT FEES	286,000	CAREPLUS MGMT INC		$	$ (286,000)	1	-286000
V	19	ADMIN. CONSULTANT FEE	137,500				(137,500)	2	-137500
V	19	DATA PROCESSING FEE	8,800				(8,800)	3	-8800
V	22	CLERICAL FEES	68,200				(68,200)	4	-68200
V	1	DIETARY CONSULTANT FEE	4,950				(4,950)	5	-4950
V	2	DIETARY SALARIE				7,958	7,958	6	7958
V	5	ELECTRICITY				378	378	7	378
V	6	REPAIRS				667	667	8	667
V	6	MAINTENANCE SALARIE				10,184	10,184	9	10184
V	10	NURSING				21,837	21,837	10	21837
V	7Bb	THERAPY SALARIE				5,838	5,838	11	5838
V	7Bb	THERAPY FEES				45,650	45,650	12	45650
V	23	PROFESSIONAL FEES				2,017	2,017	13	3017
Total			505,450			$ 95,529	$ * (409,921)	14	

* Total must agree with the amount recorded on line 30 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

Print Preview

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Print Page 6A

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	34	RENT	$ 464,438	AVENUE ASSOCIATES LLC		$	$ (464,438)	15	-464438
16	V	30	SL DEPRECIATION				119,246	119,246	16	119246
17	V	32	INTEREST				398,805	398,805	17	398805
18	V								18	
19	V								19	
20	V	20	DUES/LICENSES/WANT ADS		CAREPLUS MGMT INC		1,074	1,074	20	1074
21	V	21	OFFICE SALARIES/EXPENSES		" "		52,666	52,666	21	52666
22	V	23	SEMINARS		" "		886	886	22	886
23	V	24	TRAVEL		" "		98	98	23	98
24	V	25	TRANSPORTATION		" "		1,118	1,118	24	1118
25	V	26	INSURANCE		" "		3,326	3,326	25	3326
26	V	27	EMPLOYEE BENEFITS		" "		23,153	23,153	26	23153
27	V	30	SL DEPRECIATION		" "		8,239	8,239	27	8239
28	V	32	INTEREST		" "		826	826	28	826
29	V	34	OFFICE RENT		" "		5,030	5,030	29	5030
30	V	35	EQUIP RENT/AUTO LEASE	14,784	" "		6,279	(8,505)	30	-8505
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 479,222			$ 620,746	$ * 141,524	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6B

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6B
15	V	10A	THERAPY SERVICES	$ 26,310	CAREPLUS REHABILITATIVE SERVOCES		$ 18,580	$ (7,730)	15	-7730
16	V	39	ANCILLARY THERAPY	90,252			63,737	(26,515)	16	-26515
17	V								17	
18	V								18	
19	V								19	
20	V								20	
21	V								21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 116,562			$ 82,317	$ * (34,245)	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6C

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
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Print Page 6D

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	SHERWIN I. RAY	PRESIDENT	ADMINICTRAT,	48.87	SEE ATTACHE D	4.2	7.06	SALARY	13,057	17-7	2
3			FINANCE,		SCHEDULES						3
4			BANKING								4
5											5
6	ROSLYN INDICH	CLERICAL	CLERICAL	9.667		4.2	7.06	SALARY	2,441	21-7	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 15,498		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS [Show Pgs 8A thru 8D] [Show Pgs 8E thru 8I] [Hide Pgs 8A thru 8I]

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT, INC.
Street Address: 5940 W. TOUHY
City / State / Zip Code: NILES, 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	559,284	11	$ 97,227	$ 97,227	45,779	$ 7,958	1
2	5	ELECTRICITY	" "	648,651	14	5,352		45,779	378	2
3	6	REPAIRS	" "	648,651	14	9,448		45,779	667	3
4	6	MAINTENANCE SALARIES	" "	648,651	14	144,297	144,297	45,779	10,184	4
5	10	NURSING	" "	648,651	14	309,417	309,417	45,779	21,837	5
6	10a	THERAPY SALARIES	" "	578,314	12	73,756	73,756	45,779	5,838	6
7	17	ADMIN SALARIES	" "	648,651	14	646,825	646,825	45,779	45,650	7
8	19	PROFESSIONAL FEES	" "	648,651	14	42,748		45,779	3,017	8
9	20	DUES/LICENSES/WANT ADS	" "	648,651	14	15,220		45,779	1,074	9
10	21	OFFICE SALARIES/EXPENSES	" "	648,651	14	746,225	559,379	45,779	52,666	10
11	23	SEMINARS	" "	648,651	14	12,554		45,779	886	11
12	24	TRAVEL	" "	648,651	14	1,390		45,779	98	12
13	25	TRANSPORTATION	" "	648,651	14	15,846		45,779	1,118	13
14	26	INSURANCE	" "	648,651	14	47,123		45,779	3,326	14
15	27	EMPLOYEE BENEFITS	" "	648,651	14	328,053		45,779	23,153	15
16	30	SL DEPRECIATION	" "	648,651	14	116,734		45,779	8,239	16
17	32	INTEREST	" "	648,651	14	11,707		45,779	826	17
18	34	OFFICE RENT	" "	648,651	14	71,276		45,779	5,030	18
19	35	EQUIP RENT/AUTO LEASE	" "	648,651	14	88,968		45,779	6,279	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,784,166	$ 1,830,901		$ 198,224	25

Print Preview

Print Page 8A

STATE OF ILLINOIS

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: AVENUE ASSOCIATES LLC
Street Address: 5940 W. TOUHY
City / State / Zip Code: NILES, IL 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	SL DEPRECIATION	DIRECT COST	1	1	$ 119,246	$	1	$ 119,246	1
2	32	INTEREST	DIRECT COST	1	1	398,805		1	398,805	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 518,051	$		$ 518,051	25

Print Preview

Print Page 8B

STATE OF ILLINOIS

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8C

STATE OF ILLINOIS

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Print Page 8D

STATE OF ILLINOIS

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY: AVENUE ASSOCIATES LLC						$	$			$	1
2	PACIFIC MUTUAL		X	MORTGAGE	$38,703.00	12/95	4,657,452	4,338,808	1/08	0.0888	388,965	2
3			X	LOAN COST	W/O OVER 12	12/95	118,077	68,109	1/08		9,840	3
4					YEARS							4
5	CAREPLUS MANAGEMENT ALLOCATION							909				5
	Working Capital											
6	CAREPLUS MGMT INC	X		WORKING CAPITAL	DEMAND		750,000	(220,500)		PRIME+	2,548	6
7	FIRST PREMIUM		X	INSURANCE FINANCING							494	7
8												8
9	TOTAL Facility Related				$38,703.00		$ 5,525,529	$ 4,187,326			$ 401,847	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,525,529	$ 4,187,326			$ 401,847	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	160,170	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	157,524	2
3. Under or (over) accrual (line 2 minus line 1).	$	(2,646)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	159,100	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	156,454	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	109,326	8
	1996	112,016	9
	1997	155,823	10
	1998	158,589	11
	1999	157,524	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,293 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 0
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 0
4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	51,736	1995	$ 100,000	1
2					2
3	TOTALS	51,736		$ 100,000	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5	155		1995	1971	4,046,250	103,746	39	103,746		609,649	5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	SPRINKLER SYSTEM			1988	5,400	171	25	216	45	2,718	9
10	LEASEHOLD IMPROVEMENTS			1989	1,035	33	20	52	19	572	10
11	LEASEHOLD IMPROVEMENTS			1990	5,400	171	20	270	99	2,857	11
12	LEASEHOLD IMPROVEMENTS			1991	14,414	457	20	721	264	6,850	12
13	LEASEHOLD IMPROVEMENTS			1992	42,003	1,384	31.5	1,333	(51)	11,656	13
14	LEASEHOLD IMPROVEMENTS			1993	16,403	433	31.5	521	88	3,907	14
15	LEASEHOLD IMPROVEMENTS			1993	1,081	72	15	72		540	15
16	LEASEHOLD IMPROVEMENTS			1994	15,686	402	39	402		2,681	16
17	LEASEHOLD IMPROVEMENTS			1994	9,604	858	20	480	(378)	3,120	17
18	ELEVATOR REPAIR & DOOR			1995	44,614	1,144	39	1,144		6,054	18
19	PAVING			1995	3,600	240	15	240		1,320	19
20	ALARM SYSTEM			1996	1,820	47	39	47		221	20
21	PLUMBING			1996	2,737	70	39	70		324	21
22	WALK-IN COOLER			1996	9,998	256	39	256		1,095	22
23	DOORS AND ROOF REPAIR			1997	5,110	131	39	131		504	23
24	FENCE			1997	19,800	508	39	508		1,799	24
25	FLOORING/BUMPER GUARDRAILS/HANDRAILS			1997	30,579	785	39	784	(1)	2,660	25
26	BUILT-IN NURSES' STATION & WARDROBES			1997	26,176	671	39	671		2,350	26
27	SMOKE & FIRE DAMPERS			1998	7,100	182	39	182		401	27
28	ELEVATOR REPAIR AND LAUNDRY ROOM ELECTRICAL/CIRCUI			1998	5,931	152	39	152		402	28
29	PARKING LOT PAVING AND LANDSCAPING			1998	53,109	3,542	15	3,541	(1)	8,851	29
30	FLOORING			1998	11,516	295	39	295		726	30
31	FIRE SAFETY UPGRADE/LIGHTING/EXHAUST/ROOF			1999	57,028	1,462	39	1,462		2,253	31
32	ONE SUMP PUMP ASSEMBLY			2000	4,200	19	27.5	19		19	32
33	RELOCATION OF A/C UNIT			2000	3,015	14	27.5	14		14	33
34	INSTALL PULL STATION & REWIRE BLDG			2000	5,878	27	27.5	27		27	34
35	CAREPLUS MGMT INC: LESEHOLD IMPROVEMENTS					75		75			35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 117,347		$ 117,431	$ 84	$ 673,570	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
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	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12C

STATE OF ILLINOIS

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2

**Improvement type must be detailed in order for the cost report to be considered complete

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12D

STATE OF ILLINOIS

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 184,053	$ 19,972	$ 16,690	$ (3,282)	3-15 YR	$ 84,267	37
38	Current Year Purchases	2,689	384	135	(249)	10 YR	135	38
39	Fully Depreciated Assets	12,324				8-10 YR	12,324	39
40	RELATED PARTY-ALLOC SL DEPR		23,664	23,664				40
41	TOTALS	$ 199,066	$ 44,020	$ 40,489	$ (3,531)		$ 96,726	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 161,367	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 157,920	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (3,447)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 770,296	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 26,216 Description: SEE SCHEDULE ATTACHED
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY TRAINED AIDES.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 42,255	$		$ 42,255	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			47,997			47,997	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				30,866		30,866	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
	MEDICAL SUPPLIES	39-2					1,606		1,606	
13	Other (specify): LABS/RENTALS	39-2					3,885		3,885	13
14	TOTAL			$		$ 90,252	$ 36,357		$ 126,609	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (311,673)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,185,972		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,176		6
7	Other Prepaid Expenses	8,805		7
8	Accounts Receivable (owners or related parties)	220,500		8
9	Other(specify): REAL ESTATE TAX ESCROW	55,342		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,186,122	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	393,633		15
16	Equipment, at Historical Cost	208,670		16
17	Accumulated Depreciation (book methods)	(218,953)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	58,056		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DUE FROM ANENUE LLC	442,558		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 883,964	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,070,086	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 192,902	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	34,423		28
29	Short-Term Notes Payable	54,875		29
30	Accrued Salaries Payable	67,305		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,970		31
32	Accrued Real Estate Taxes(Sch.IX-B)	159,100		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	4,500		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 523,075	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 523,075	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,547,011	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,070,086	$	48

***(See instructions.)**

Print Preview

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,394,949	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	(99,974)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,294,975	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	499,976	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(247,940)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 252,036	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,547,011	24 *

*** This must agree with page 17, line 47.**

Print Preview

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,599,463	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,599,463	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	2,092	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,092	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	46	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 46	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	900	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 900	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,602,501	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 768,350	31
32	Health Care	1,340,186	32
33	General Administration	1,098,252	33
	B. Capital Expense		
34	Ownership	684,032	34
	C. Ancillary Expense		
35	Special Cost Centers	126,609	35
36	Provider Participation Fee	85,096	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,102,525	40
41	**Income before Income Taxes (line 30 minus line 40)****	499,976	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 499,976	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.** **TAX RETURN NOT YET PREPARED**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Print Preview

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,050	2,163	$ 48,860	$ 22.59	1
2	Assistant Director of Nursing	1,954	1,992	40,728	20.45	2
3	Registered Nurses	4,923	4,939	103,230	20.90	3
4	Licensed Practical Nurses	26,237	27,000	402,373	14.90	4
5	Nurse Aides & Orderlies	65,895	68,874	507,853	7.37	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,462	5,925	49,522	8.36	8
9	Activity Director					9
10	Activity Assistants	9,320	9,952	66,078	6.64	10
11	Social Service Workers	1,632	1,648	25,922	15.73	11
12	Dietician					12
13	Food Service Supervisor	2,687	2,825	22,545	7.98	13
14	Head Cook	286	321	1,784	5.56	14
15	Cook Helpers/Assistants	16,547	17,226	97,541	5.66	15
16	Dishwashers					16
17	Maintenance Workers	3,951	4,270	33,813	7.92	17
18	Housekeepers	18,199	19,232	110,416	5.74	18
19	Laundry	6,327	6,918	44,016	6.36	19
20	Administrator	1,845	2,017	51,157	25.36	20
21	Assistant Administrator	840	856	14,817	17.31	21
22	Other Administrative					22
23	Office Manager	72	72	504	7.00	23
24	Clerical	5,184	5,478	76,124	13.90	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,680	1,811	13,424	7.41	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	175,091	183,519	$ 1,710,707 *	$ 9.32	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 4,950	1-3	35
36	Medical Director	O	0	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	840	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	3,429	11-3	44
45	Social Service Consultant	E	4,861	12-3	45
46	Other(specify)	E			46
47	PSYCHO-SOCIAL CONSULTAN	S	564	10-3	47
48					48
49	TOTAL (lines 35 - 48)		$ 25,444		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Print Preview

0

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
EUGENE BERGER	ADMIN	0.00%	$ 51,157
LAWRENCE ROBINSON	ASST ADMIN	0.00%	14,817
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 65,974

B. Administrative - Other

Description	Amount
CAREPLUS MANAGEMENT - MANAGEMENT FEES	$ 286,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 286,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
CARE PLUS	DATA PROCESSING	$ 8,800
AMERICAN DATA	DATA PROCESSING	2,400
HDSI	DATA PROCESSING	1,921
CARE PLUS	ADMIN. CONSULTANT	137,500
KRUPNICK,BOKOR, KAGDA	ACCOUNTING FEES	21,150
MEYER MAGENCE	LEGAL FEES	3,533
ART ROUSEAU	LEGAL FEES	125
WINSTON & STRAWN	LEGAL FEES	1,037
ECONOCARE	PURCHASE CONSULT	1,627
PERSONNEL PLANNERS	UC CONSULT	2,146
RICHARD PEELO	MEDICARE CONSULT	3,750
FIRST REAL ESTATE	APPRAISAL SERVICE	2,600
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 186,589

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 20,759
Unemployment Compensation Insurance	23,759
FICA Taxes	130,704
Employee Health Insurance	62,236
Employee Meals	20,093
Illinois Municipal Retirement Fund (IMRF)*	
PENSION/PROFIT SHARING CONTRIB	19,421
EMPLOYEE BENEFITS-OTHER	2,085
EMPLOYEE PHYSICAL EXAMS	0
INSURANCE EXECUTIVE LIFE	0
CHICAGO HEAD TAX	4,644
RELATED PARTY	0
INSURANCE EXECUTIVE LIFE	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 283,701

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	13,138
Health Care Worker Background Check	330
(Indicate # of checks performed 28)	
ADV & PROMO/MARKETING	2,628
DUES & SUBSCRIPTIONS	5,448
LICENSES & PERMITS	2,072
TRUST FEES, CONTRIBUTIONS,etc.	175
MGMT CO ALLOCATION	1,074
LESS TRUST FEES, CONTRIB, etc.	(175)
Less: Public Relations Expense	( )
Non-allowable advertising	(1,979)
Yellow page advertising	(649)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,062

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	0
RELATED PARTY	98
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 98

* Attach copy of IMRF notifications

**See instructions.

Print Preview

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINT/DECORATINC	1997	$ 14,889	3	$ 2,482	$ 4,963	$ 4,963	$ 2,481	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 14,889		$ 2,482	$ 4,963	$ 4,963	$ 2,481	$	$	$	$	$

Print Preview

Facility Name & ID Number AVENUE CARE CENTER # 0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? YES

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE $ 4955

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 0 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 85,096
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 20,093 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Print Preview

Facility Name & ID Number AVENUE CARE CENTER #0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
1	DIETARY			
	DIETITIAN CONSULTANT	XVIII B35	4950	
	REPAIRS & MAINTENANCE		310	
			0	5260
3	HOUSEKEEPING			
			0	
			0	0
4	LAUNDRY			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	HEAT & OTHER UTILITIES			
	GAS HEAT		46777	
	ELECTRICITY		42323	
	WATER		24365	
	CABLE TV - LOBBY		1485	
			0	114950
6	MAINTENANCE			
	GROUNDS MAINTENANCE		995	
	PAINTING & DECORATING		1342	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		17150	
	ELEVATOR MAINTENANCE & REPAIR		16843	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		6300	
	FIRE SERVICE		5246	
			0	
			0	
			0	47876
7	OTHER			
	SCAVENGER		12022	
	SECURITY SERVICE		0	12022
9	MEDICAL DIRECTOR			
	MEDICAL DIRECTOR FEES	XVIII B36	0	0
10	NURSING			
	CONTRACT NURSING	XVIII C53	0	
	LABORATORY & XRAY EXPENSE		410	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B47	564	
	RESTORATIVE NURSING CONSULTANT	XVIII B38	0	
	MEDICAL RECORDS CONSULTANT	XVIII B37	0	
	PHARMACY CONSULTANT	XVIII B39	840	
	UTILIZATION REVIEW FEES	XVIII B	0	
	PHYSICIANS	XVIII B	0	
	PSYCHIATRIC	XVIII B	0	
	RN CONSULTANT	XVIII B38	0	
			0	
			0	1814
10a	THERAPY			
	THERAPY CONTRACT SERVICES		15638	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B40	5400	
	OCCUPATIONAL THERAPY CONSULTAN	XVIII B41	5400	
	SPEECH THERAPY CONSULTANT	XVIII B43	0	
	RESPIRATORY CONSULTANT	XVIII B42	0	26438
11	ACTIVITIES			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B44	3429	
			0	3429
12	SOCIAL SERVICES			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTANT	XVIII B45	0	
	SOCIAL WORKER	XVIII B45	4861	
			0	4861
13	NURSE AIDE TRAINING			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number AVENUE CARE CENTER #0033340 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF		TOTAL
14	PROGRAM TRANSPORTATION			
	PATIENT TRANSPORTATION		958	958
17	ADMINISTRATIVE			
	MANAGEMENT FEES	XIX B	286000	286000
18	DIRECTORS FEES		0	0
19	PROFESSIONAL SERVICES			
	DATA PROCESSING	XIX C	13121	
	ADMINISTRATIVE CONSULTANTS	XIX C	137500	
	PROFESSIONAL FEES	XIX C	35968	
	ACCOUNT COLLECTION FEES		0	186589
20	FEES,SUBSCRIPTIONS,PROMOTIONS			
	ENTERTAINMENT	VI 19 XIX F	0	
	ADV & PROMO/MARKETING	VI 25 XIX F	1979	
	EMPLOYEE WANT ADS	XIX F	13138	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	5448	
	LICENSES & PERMITS	XIX F	2072	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	649	
	TRUST FEES/FRANCHISE TAX	VI 17 XIX F	54	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	121	
	H/CARE WORKER BACKGROUND CHECK	XIX F	330	23791
21	CLERICAL & GENERAL OFFICE EXPENSES			
	BANK CHARGES		3898	
	EQUIPMENT REPAIR & MAINTENANCE		6259	
	OUTSIDE CLERICAL SERVICES		68200	
	PENALTIES	VI 18	2004	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		27443	
	MESSENGER SERVICE		0	
			0	107804
22	EMPLOYEE BENEFITS & PAYROLL TAXES			
	FICA TAXES	XIX D	130704	
	UNEMPLOYMENT COMPENSATION	XIX D	23759	
	WORKERS COMPENSATION INSURANCE	XIX D	20759	
	HOSPITALIZATION INSURANCE	XIX D	62236	
	EMPLOYEE BENEFITS - OTHER	XIX D	2085	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	UNION PENSION FUND/401-K EXPENCE	XIX D	19421	
	CHICAGO HEAD TAX	XIX D	4644	263608
23	INSERVICE TRAINING & EDUCATION			
	EDUCATION & SEMINARS		1590	1590
24	TRAVEL & SEMINARS			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	0
25	ADMIN. STAFF TRANSPORTATION			
	TRANSPORTATION - STAFF		648	648
26	INSURANCE - PROP. LIAB & MALPRACTICE			
	GENERAL INSURANCE		74080	74080
27	OTHER			
	BAD DEBTS	VI 24	0	
			0	0
	GRAND TOTAL COLUMN 3 OTHER			1161718

Facility Name & ID Number AVENUE CARE CENTER #0033340
EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 COLUMN 3 OTHER LINES 2 AND 22

TOTAL FOOD PURCHASE	186151	PATIENT MEALS	136749
LESS SALES TAX	-606	ADD EMPLOYEE MEALS	16470
NET FOOD	186757	TOTAL MEALS/YEAR	153219
TOTAL PATIENT CENSUS	45583	NET FOOD	186757
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	153219
TOTAL PATIENT MEALS	136749	COST PER MEAL	1.22
		TIME EMPLOYEE MEALS	16470
ADD # EMPLOYEE MEALS/DAY	45		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	20093
TOTAL EMPLOYEE MEALS	16470		